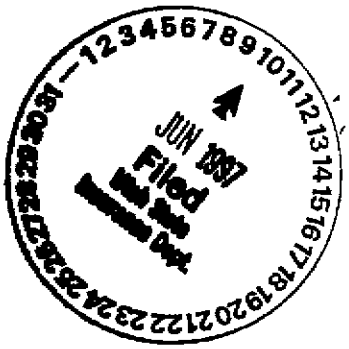

STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF MARKET CONDUCT EXAMINATION

of

CIGNA HEALTHCARE OF UTAH, INC.

5295 South 320 West, #280
Salt Lake City, Utah 84107

as of

June 30, 1996

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May 8, 1997

The Honorable Merwin U. Stewart
Insurance Commissioner
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

In accordance with your instructions, an examination has been made of the market conduct practices of

CIGNA HEALTHCARE OF UTAH, INC.
Salt Lake City, Utah

a health Maintenance organization, hereinafter referred to as the Company, as of June 30, 1996. The report of such examination is herein respectfully submitted.

FOREWORD

The market conduct examination report is, in general, a report by exception. Reference to Company practices, procedures, or files subject to review may be omitted if no improprieties are indicated.

SCOPE OF EXAMINATION

This examination was conducted by an examiner representing the Utah Insurance Department in accordance with the Model Market Conduct Examination Handbook of the National Association of Insurance Commissioners and Utah Code Annotated (U.C.A.) 31A-2, Administrations of the Insurance Laws. The period covered by the examination was January 1, 1990 to June 30, 1996. Where considered appropriate, transactions of the Company prior and subsequent to the examination period were reviewed.

The purpose of the examination was to determine the Company's compliance with the Utah Insurance Code (U.C.A. 31A), and Rules promulgated by the Utah Insurance Department as contained in the Utah Administrative Code (U.A.C.) applicable to U.C.A. 31A, and to determine if Company operations were consistent with public interest.

COMPANY PROFILE

History

The Company was issued a Certificate of Incorporation under the name of HCA Care of Utah, Inc by the Office of the Lieutenant Governor of the State of Utah. HCA Care of Utah, Inc. was a subsidiary of Hospital Corporation of America. The Certificate of Incorporation was dated January 30, 1985. The Company received its Certificate of Authority from Utah On September 17, 1985 and commenced doing business on January 1, 1986 as a health maintenance organization.

On October 1, 1986, ownership of the Company was acquired by Equicor-Equitable HCA Corporation, a joint venture of Hospital Corporation of America and Equitable Life Assurance Society of the United States. The Company's name was changed to Equicor Health Plan of Utah, Inc. on June 23, 1987. CIGNA Corporation purchased the Company, along with a number of other health maintenance organizations, as of March 29, 1990. The Company's name was subsequently changed to CIGNA HealthPlan of Utah, Inc. on December 17, 1990, and to CIGNA HealthCare of Utah, Inc. on September 1, 1993.

As of December 31, 1994, 100% of the Company's issued and outstanding shares of stock was owned by CIGNA HealthCare, Inc. On July 3, 1995, CIGNA HealthCare, Inc. was merged

with and into CIGNA Health Corporation. As a result of the merger, CIGNA Health Corporation owns 100% of the Company's outstanding shares of stock.

Affiliated Companies

The Company is a member of an insurance holding company system and the ultimate controlling person within that system is CIGNA CORPORATION. The following is a direct organizational chart from the Company to the ultimate controlling person:

CIGNA CORPORATION
CIGNA Holdings, Inc.
Connecticut General Corporation
CIGNA Health Corporation
CIGNA HealthCare, Inc.
CIGNA HealthCare of Utah, Inc.

Effective June 1, 1990, the Company entered into an agreement with Connecticut General Life Insurance Company, acting on its own behalf and on behalf of groups sponsoring certain insured or self-insured health benefit plans. This agreement, referred to as "FlexCare", enables Connecticut General Life Insurance Company to use the Company's registrant provider networks. Connecticut General Life Insurance Company or the individual group retains liability for all benefits under the plan and pays the Company administrative charges for its services.

The Company entered into an agreement on January 1, 1994 with CIGNA HealthCare, Inc. Under this agreement, CIGNA HealthCare, Inc. provides many of the services necessary for the Company's operation, including sales support, underwriting, personnel services, employee recruiting and staffing services, claims processing, systems services, tax planning and tax return preparation, membership services, treasury and banking services, corporate training, administrative services, payroll services, legal services, marketing and advertising support, financial services, real estate services, procurement of insurance coverages, and such other services as the parties might agree upon.

Territory and Plan of Operations

The Company has a certificate of authority to transact business as a health maintenance organization in the state of Utah. It is described as a non-federally qualified independent physicians association (IPA) type health maintenance organization and is a for-profit corporation.

As of June 30, 1996 the Company had contracts with 1444 independent physicians, 12 hospitals, and other health care providers to deliver health care services to its members in Weber, Davis, Salt Lake, Utah, and parts of Box Elder, Cache, Morgan, Summit, Tooele, Wasatch, Juab, and Sanpete Counties. Primary care providers are generally paid on a capitation basis. Specialist physicians, hospitals and other participating providers are paid on a modified fee-for-service basis.

All providers are authorized to retain co-payments made by members at the time of service. Providers may bill additional insurers, such as the Worker's Compensation Fund and Medicare, directly for services provided to members.

New and renewal business is solicited by in-house agents and outside independent agents. The Company does not use managing general agents as part of their agency force. The Company markets to groups having 25 or more employees, however, it will accept groups with as few as ten enrollees. Enrollment as of June 30, 1996 was comprised of the following:

Group Classification	Member Enrollees
Commercial	9,534
ASO (FlexCare)	24,628
Individual	5
Total	34,167

The Company advertises in newspapers, magazines, television, radio, and on billboards adjacent to highways within Utah in the greater Salt Lake City, Provo and Ogden areas.

Policy Forms and Rates

There are three different health policy forms offered by Company, two pertaining strictly to health maintenance organization (HMO) plans and one pertaining to an HMO plan with a point of service (POS) option. The "in network" portion of the POS option plan is underwritten by the Company, with the "out of network" portion underwritten by Connecticut General Life Insurance Company. The newest of the HMO forms, referred to by the Company as "96GSA", is available to all group sizes of ten or more enrollees. It is the only product currently offered by the Company to small groups of fifty or less employees. The other strictly HMO form, referred to by the Company as "94GSA", is currently offered only to large groups of fifty-one or more employees, as is the POS option form. Prior to the new 96GSA form, both the 94GSA form and the POS option form were offered to all group sizes of ten or more employees.

The 94GSA form and the 96GSA form vary in terms, benefits, limitations, and co-payment amounts, generally more favorable in the 94GSA form. The "in network" portion of the POS option form is identical to the 94GSA form in terms, benefits, limitations, and co-payments. Each of the three policy forms offer a variety of co-payment options to the subscribers.

Rating factors used by the Company in the development of its rates include benefit design, age, gender, family composition, geographic area, industry, and claims experience.

Reinsurance

The Company has reinsurance coverage through an agreement with Connecticut General Life Insurance Company. Under the terms of the agreement, the Organization is reimbursed for 80% of the retained liability in excess of a $150,000 deductible for hospital services per member per calendar year. In the event the Company becomes insolvent, Connecticut General Life Insurance Company will assume responsibility for costs of covered service until the end of the period of time for which premium has been paid.

Company Growth

The table below reports the Company's growth in membership and premium for the last six years. Numbers were taken from the Company's filed annual statements.

Year	Year End Member Enrollment	Year End Premium & Related Revenue
1995	43,436	$17,781,084
1994	37,493	18,081,364
1993	21,236	26,732,278
1992	22,506	22,276,556
1991	15,339	17,179,260
1990	15,270	12,738,644

PREVIOUS EXAMINATION FINDINGS

The previous market conduct examination report as of September 30, 1989 and financial examination report as of December 31, 1994 were reviewed. Company responses to the findings and recommendations of the market conduct examination report were also reviewed. All of the recommendations were addressed and corrective actions were taken by the Company.

CURRENT EXAMINATION FINDINGS

Certificate of Authority

The Company's Certificate of Authority was reviewed and found to be current. The Company is operating within the parameters of its Certificates of Authority. No discrepancies were noted.

Producer Relationships

U.C.A. Section 31A-23-305 requires every insurer to be bound by any act of its agent performed within the scope of the agent's actual (express or implied) or apparent authority. U.C.A. Section 31A-23-311 requires the insurer to be liable to the insured for losses if the premium was received by an agent who placed the insurance. U.C.A. Section 31A-23-219 states there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee acted as the insurer's agent. However, the Company's Producer Blanket Agreement states that in offering products to customers, the "Producer understands that he or she is not acting as Company's agent." The agreement also states that in collecting insurance premiums, the "Producer understands that he or she is not Company's agent" for receipt of the premiums collected. This language in the agreement between the Company and producer is in conflict with U.C.A. Sections 31A-23-219, 305, and 311.

Seventeen agents produced business for the Company prior to being appointed by the Company. Twenty-one agents produced business for the Company when no agency contract was in effect. Three agents were licensed and appointed under one name, but commissions were paid under a different name. At least twelve agents were paid commissions by the Company prior to having an appointment and/or written agency contract in effect. Producing business without an appointment and a written agency contract in effect is a violation of U.C.A. Section 31A-23-309. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A Subsection 31A-23-219(1).

Unintentional delays and inaccurate information was provided by the Company in response to information requested by the examiner concerning the producer relationships area examined.

Marketing and Sales

The Company advertises through various mediums, including television, radio, newspapers, magazines, billboards and point of sale brochures and flyers. Company products are marketed to prospective purchasers both through in-house agents and outside independent agents. Company marketing and sales materials were reviewed, including sales presentation manuals and sales training materials, advertising, sales brochures and flyers, application forms and other materials. No discrepancies were noted.

Company Forms/Required Filings

Policy forms and other required filings were reviewed. As of the date of the examination exit conference, the Company had not yet properly filed an actuarial certification certifying that the Company is in compliance with U.C.A. 31A-30, Individual and Small Employer Health Insurance Act, and that the rating methods of the Company are actuarially sound. In an effort to file the certification in October 1996, the Company failed to submit the required transmittal letter or filing fee and the unfiled certification was therefore returned to the Company by the Utah Insurance Department. Failure to file the actuarial certification on or before March 15 of each year is a violation of U.C.A. Subsection 31A-30-106(4)(b) and U.A.C. Subsection R590-167-12.A.

U.A.C. R590-167, Individual and Small Employer Health Insurance Rule, requires a separate rate manual be developed for each class of small employer group business, and a copy of the applicable rating manual be filed for every health benefit plan subject to that rule. The Company has only one class of small employer group business. As of the date of the examination exit conference, the Company had not yet properly filed a copy of the rating manual for that class of business with the Utah Insurance Department. In an effort to file the rating manual in October 1996, the Company failed to submit the required transmittal letter or filing fee and the unfiled rating manual was therefore returned to the Company by the Utah Insurance Department. Failure to file a copy of the rating manual for every health benefit plan subject to U.A.C. R590-167 on or before February 15, 1996 is a violation of U.A.C. Subsection R590-167-12.B.

U.A.C. R590-167 requires a list of every policy form to which the rule applies be filed no later than March 15 of each year. The Company did not file the list of policy forms in a timely manner. Failure to file the list of every policy form to which the rule applies by March 15 of each year is a violation of U.A.C. Subsection R590-167-12(C).

Underwriting/Rating

The Company markets to groups having twenty-five or more employees and will provide quotations to applicant groups with at least fifteen eligible employees. The Company will not issue policies to employers with less than ten of the eligible employees enrolling in the policy. Individual members of the group are not medically underwritten by the Company.

All group applications require extensive information from the agent and the applicant. Upon reviewing the information supplied, the Company decides whether to continue the quotation process or to decline to quote. If the decision is to continue, the application and supporting documentation is forwarded to the small group underwriting unit, Small Case Organization Requisition, in Anaheim, California or to the large group underwriting unit in Phoenix, Arizona for underwriting and pricing. The quotation is returned to the Company and given to the agent who requested it. If the quotation is accepted by the applicant, the appropriate underwriting unit

is notified and the necessary information is forwarded to the Employer Account Service Center in Phoenix, Arizona, previously referred to during the examination period as the Business Service Center, where the policy is prepared. The Employer Account Service Center forwards the policy to the Company for delivery to the insured. Enrollment meetings are then held during which the insured's employees and their dependents are enrolled.

The Company has limited its liability through the use of policy limitations and exclusions, co-payments for services rendered, exclusive use of Company authorized providers for non-emergency care, and pre-authorization of specialized medical procedures.

Rating factors used by the Company in the development of its rates include benefit design, age, gender, family composition, geographic area, industry, and claims experience. Rates, rating plans, and Company rating practices and procedures were reviewed. As of the date of the examination exit conference, the Company had not filed an actuarial certification certifying that the Company is in compliance with U.C.A. 31A-30 and that the rating methods of the Company are actuarially sound. Nor had the Company filed, as of that date, a copy of the rating manual for every health benefit plan subject to U.A.C. R590-167 (See Company Forms/Required Filings section above).

Consumer Complaints

The Company has written complaint and grievance procedures in place. Members may register complaints with the Company by telephone, in person, or in writing. If the complaint cannot be resolved during the initial telephone call or interview with Company personnel, it should be put in writing to initiate the grievance procedure. The written complaint will be transmitted to the appropriate Company official with authority to take corrective action. If the complainant remains dissatisfied with the decision, the member may file a written appeal for review by the Grievance Committee, which is the final administrative review of the matter. The member must initiate and complete the grievance procedure before initiating any arbitration or litigation against the Company.

The Company maintains a complaint register for all consumer complaints, and since January 1, 1994 has maintained a separate complaint register for "Department of Insurance Complaints". There have been a total of twenty-eight consumer complaints filed with the Utah Insurance Department against the Company during the examination period, of which six were listed as justified complaints. Since January 1, 1993, sixteen consumer complaints were filed with the Utah Insurance Department, of which three were justified. All sixteen of these more recent complaints were reviewed by the examiner. One of the complaints was not listed in the Company's register. This discrepancy was pointed out by the examiner and was corrected by the Company during the examination process. The following table shows the population breakdown of the complaints filed with the Utah Insurance Department, by year, and the number of those complaints reviewed.

Complaints filed with the Utah Insurance Department

	1990	1991	1992	1993	1994	1995	1996	Total
Justified Complaints	3	0	0	1	0	2	0	6
Questionable Complaints	1	3	2	5	3	4	0	18
Unjustified Complaints	2	0	1	0	1	0	0	4
Total Complaints	**6**	**3**	**3**	**6**	**4**	**6**	**0**	**28**
Complaints Reviewed	0	0	0	6	4	6	0	16

U.A.C. R590-89, Unfair Claims Settlement Practices Rule, has a fifteen day maximum response time requirement for answering Utah Insurance Department inquiries respecting claims. There were twenty-three Utah Insurance Department inquiries sent to the Company pertaining to the above sixteen consumer complaints reviewed. Two of the inquiries were not initially responded to by the Company, resulting in follow up inquiries being sent, to which the Company responded. Of the remaining twenty-one Utah Insurance Department inquiries to which the Company responded, the average time for the Company's response was nine days. Three of the twenty one inquiries were not responded to by the Company until after fifteen days. Failure to furnish the department with a substantive response within fifteen days is a violation of U.A.C. Subsection R590-89-10.B.

Since January 1, 1993, there have been a total of twenty-five direct consumer complaints concerning claims which resulted in formal grievances. All twenty five of these complaint files were reviewed by the examiner. The following table shows the population breakdown of these complaints, by year.

Complaints resulting in Formal Grievances

	1993	1994	1995	1996	Total
Complaints Reviewed	13	8	2	2	25

Company procedures allowed thirty days response time for complaints received by the Company direct from consumers. However, U.A.C. R590-89 has a fifteen day maximum response time requirement for answering pertinent communications from a claimant which reasonably suggest that a response is expected. The average time for the Company's response to grievances received from the claimants in the twenty-five files reviewed was twenty-two days. In fourteen of the twenty five files reviewed, grievances received from the claimants were not responded to by the Company until after fifteen days. In six cases, a response was not sent by the Company until after thirty days, which was in excess of the Company's own procedural requirements. Failure to respond to the claimant within fifteen days is a violation of U.A.C. Subsection R590-89-10.C. Failure to answer the grievance in writing within thirty days of submittal is a violation of U.A.C. Subsection R590-76-8.C.

According to the language in the Company's optional binding arbitration provisions, "any controversy...arising out of or in connection with this Agreement shall, upon written notice by one Party to another, be submitted to arbitration." The language states the decision of the arbitrator(s) "shall be binding upon both Parties, conclusive of the controversy in question...". It further states, "The submission of a controversy under this Section to arbitration and the rendering of a decision by the arbitrator(s) shall be conditions precedent to any rights of legal action by either Party in connection with such controversy." This optional binding arbitration provision language refers to "any controversy", which would include disputed claims within the jurisdictional limit of Utah small claims courts. Furthermore, the arbitration provision language requires such controversy, at the election of either party, to be submitted to arbitration as a condition precedent to "any rights of legal action", which would include the right to seek resolution of the dispute in a Utah small claims court having jurisdiction in the matter. Therefore, according to the language, a claimant, at the election of the Company, could be precluded from seeking a resolution on a matter in dispute through a small claims court. Optional binding arbitration provisions containing language construed to preclude any dispute resolution by any small claims court having jurisdiction is a violation of U.A.C. Subsection R590-122-4.6.

HMO Specific Requirements

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in U.C.A. 31A-8, Health Maintenance Organizations and Limited Health Plans, and in U.A.C. R590-76, Health Maintenance Organizations.

Company operations were reviewed with regard to these additional requirements, including areas of internal quality control audits, contract and certificate language, pre-existing conditions, termination of coverage, unfair discrimination, solicitation, services, grievance procedures, provider contract language, and quality assurance and reporting requirements. In six instances,

the Company failed to answer in writing grievances received from claimants within thirty days of submittal, as required in U.A.C. Subsection R590-76-8.C (see Consumer Complaints section above). No other discrepancies were noted with regard to the additional specific regulatory requirements pertaining to health maintenance organizations.

SUMMARIZATION

Summary

Comments included in this report which are considered to be significant and requiring special attention are summarized below:

1. The Company's Producer Blanket Agreement states that in offering products to customers, the "Producer understands that he or she is not acting as Company's agent." The agreement also states that in collecting insurance premiums, the "Producer understands that he or she is not Company's agent" for receipt of the premiums collected. This language in the agreement between the Company and producer is in conflict with U.C.A. Sections 31A-23-219, 305, and 311. The examiner recommends the Company change the language in its Producer Blanket Agreement to conform with Utah law. **(PRODUCER RELATIONSHIPS)**

2. Seventeen agents produced business for the Company prior to being appointed by the Company. Twenty-one agents produced business for the Company when no agency contract was in effect. Three agents were licensed and appointed under one name, but commissions were paid under a different name. At least twelve agents were paid commissions by the Company prior to having an appointment and/or written agency contract in effect. Producing business without an appointment and a written agency contract in effect is a violation of U.C.A. Section 31A-23-309. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A Subsection 31A-23-219(1). The examiner recommends procedures be implemented or changed to ensure, in all cases, producers have an appointment and written agency contract in effect prior to doing business for the Company and that they are paid under the same name in which they are licensed and appointed. **(PRODUCER RELATIONSHIPS)**

3. Unintentional delays and inaccurate information was provided by the Company in response to information requested by the examiner concerning the producer relationships area examined. The examiner recommends the Company implement the necessary procedures or changes to ensure accurate information be provided in a timely manner to regulatory examiners in future examinations. **(PRODUCER RELATIONSHIPS)**

4. As of the date of the examination exit conference, the Company had not yet properly filed an actuarial certification certifying that the Company is in compliance with U.C.A. 31A-30 and that the rating methods of the Company are actuarially sound. Failure to file the actuarial certification on or before March 15 of each year is a violation of U.C.A. Subsection 31A-30-106(4)(b) and U.A.C. Subsection R590-167-12.A. The examiner recommends the Company file the actuarial certification. **(COMPANY FORMS/REQUIRED FILINGS)**

5. As of the date of the examination exit conference, the Company had not yet properly filed a copy of the applicable rating manual for every health benefit plan subject to U.A.C. R590-167. Failure to file a copy of the rating manual by February 15, 1996 is a violation of U.A.C. Subsection R590-167-12.B. The examiner recommends the Company file a copy of the rating manual. **(COMPANY FORMS/REQUIRED FILINGS)**

6. The Company did not file, in a timely manner, a list of every policy form to which U.A.C. R590-167 applies. Failure to file a list of every policy form to which the rule applies by March 15 of each year is a violation of U.A.C. Subsection R590-167-12.C. The examiner recommends the Company file the required list by March 15 of each year. **(COMPANY FORMS/REQUIRED FILINGS)**

7. Twenty-three Utah Insurance Department inquiries were sent to the Company. Two of the inquiries were not initially responded to by the Company, resulting in follow-up inquiries being sent. Three of the inquiries were not responded to by the Company until after fifteen days. Failure to furnish the department with a substantive response within fifteen days is a violation of U.A.C. Subsection R590-89-10.B. The examiner recommends procedures be implemented or changed to ensure all Utah Insurance Department inquiries are responded to by the Company within the 15 day maximum response time requirement. **(CONSUMER COMPLAINTS)**

8. U.A.C. R590-89 has a fifteen day maximum response time requirement for answering pertinent communications from a claimant which reasonably suggest that a response is expected. However, Company procedures allowed thirty days response time for complaints received by the Company direct from consumers. The average time for the Company's response to grievances received from the claimants in the twenty-five files reviewed was twenty-two days. In fourteen of the twenty five files reviewed, grievances received from the claimants were not responded to by the Company until after fifteen days. In six cases, a response was not sent by the Company until after thirty days, which was in excess of the Company's own procedural requirements. Failure to respond to the claimant within fifteen days is a violation of U.A.C. Subsection R590-89-10.C. Failure to answer the grievance in writing within thirty days of submittal is a violation of U.A.C. Subsection R590-76-8.C. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with these response time requirements and with the Company's own procedural requirements. **(CONSUMER COMPLAINTS)**

9. Language in the Company's compulsory binding arbitration provisions could be construed to preclude dispute resolution through small claims courts. Compulsory binding arbitration provisions containing language construed to preclude any dispute resolution by any small claims court having jurisdiction is a violation of U.A.C. Subsection R590-122-4.6. The examiner recommends the Company change the language in its compulsory binding arbitration provisions to specifically not preclude dispute resolution by small claims courts having jurisdiction. **(CONSUMER COMPLAINTS)**

Examiner's Comments Reference Policyholder Treatment

Policyholders were generally treated correctly and fairly by the Company. Underwriting and rating practices appear to be fair and consistent. Complaints were generally researched and handled in a fair manner, except as otherwise noted in this report.

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

Randal A. Overstreet, CIE
Market Conduct Examiner
Examiner-in-Charge
Utah Insurance Department